Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

DENTISTRY EXAMINING BOARD

DENTAL FACULTY INFORMATION

Important:
The board shall grant a license to practice dentistry to an applicant who is *licensed in good standing to practice dentistry in another jurisdiction approved by the board* upon presentation of the license and who submits the following information to the Dentistry Examining Board at the above address:

1. **APPLICATION FOR DENTAL LICENSE (FORM #2650).** Please complete a current application.

2. **LICENSURE FEE.** Checks or money orders are to be made payable to the Department of Regulation and Licensing.

3. **VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION.** Please request the state/country board where you hold a current dental license to submit a letter of verification to the Wisconsin Dentistry Examining Board. This letter must indicate your license number, date of issuance, status, and a statement regarding disciplinary actions. This letter is required in order to complete your application for licensure.

4. **NATIONAL PRACTITIONER DATA BANK.** Applicants must request the "Practitioner Request for Information Disclosure" (Self-Query) from the National Practitioner Data Banks web site: www.npdb.hipdb.com/welcomesq.html. **OPEN THE ENVELOPE** to be certain your application was processed. If processed, mail all contents, including the envelope, to the Dentistry Examining Board at the above address. Further questions regarding this form may be directed to the Data Bank Help Line at 1-800-767-6732.

5. **OTHER.** Include explanations on attached sheets, if required, for answers to questions on the Application for Dental License (Form #2650).

6. **INITIAL INTERVIEW.** Once items 1-6 are complete, this application will be submitted for initial review. You will then be scheduled to appear before the board at the next regularly scheduled meeting.

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DENTISTRY EXAMINING BOARD

APPLICATION FOR A DENTAL FACULTY LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

Name of Dental School From Which You Graduated: _____

School Address: _____
(City) (State)

Date of Graduation: _____
month /day/year

Degree: _____

Specialty: _____

APPLICATION FEE: (Make check payable to Department of Regulation and Licensing and attach to application).

_____ Dental Faculty License

$ 131.00 Total fee attached

For Receipting Use Only

#2650 (12/03)
Ch. 447, Stats.

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee attached to application.

Verification of dental license from another jurisdiction in which you are currently licensed to practice dentistry.

Initial interview with the Board.

National Practitioner Data Bank (Self-Query) Report.

Social Security Number (page 5 of 5, Form #1431).

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	YES	NO
1. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
2. Have you ever failed to pass any state board examination, national board examination, or NBE/CCT examination? If yes, give details on an attached sheet.	☐	☐
3. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
4. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
5. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
6. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
7. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and, if applicable, list name, address and phone number of your probation or parole officer.	☐	☐
8. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
9. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s)	☐	☐
10. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐
11. Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	☐	☐

AFFIDAVIT OF APPLICANT

(Sign and date <u>in the presence of</u> a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Dentistry Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of_____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

SEAL

_____
Date Commission Expires

Wisconsin Department of Regulation & Licensing

APPLICATION FOR A DENTISTRY FACULTY LICENSE

TO BE COMPLETED BY THE DEAN OF A WISCONSIN SCHOOL OF DENTISTRY

I, _____, Dean of _____
(name) (school name)

located in _____, Wisconsin, hereby certify that
(city)

_____, D.D.S./D.M.D., has been offered employment as a **full-time**
(name of applicant)

faculty member at the above-named dental school effective _____, 20_____.
(month/day) (year)

SCHOOL S E A L

_____
Signature of Dean

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.